

Senate Study Bill 1167 - Introduced

SENATE/HOUSE FILE _____
BY (PROPOSED DEPARTMENT OF
HEALTH AND HUMAN SERVICES
BILL)

A BILL FOR

1 An Act relating to the Medicaid program including third-party
2 recovery and taxation of Medicaid managed care organization
3 premiums.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

MEDICAID PROGRAM THIRD-PARTY RECOVERY

1
2
3 Section 1. Section 249A.37, Code 2023, is amended by
4 striking the section and inserting in lieu thereof the
5 following:

6 **249A.37 Duties of third parties.**

7 1. For the purposes of this section, "*Medicaid payor*",
8 "*recipient*", "*third party*", and "*third-party benefits*" mean the
9 same as defined in section 249A.54.

10 2. The third-party obligations specified under this section
11 are a condition of doing business in the state. A third party
12 that fails to comply with these obligations shall not be
13 eligible to do business in the state.

14 3. A third party that is a carrier, as defined in section
15 514C.13, shall enter into a health insurance data match program
16 with the department for the sole purpose of comparing the
17 names of the carrier's insureds with the names of recipients
18 as required by section 505.25.

19 4. A third party shall do all of the following:

20 a. Cooperate with the Medicaid payor in identifying
21 recipients for whom third-party benefits are available
22 including but not limited to providing information to determine
23 the period of potential third-party coverage, the nature of
24 the coverage, and the name, address, and identifying number
25 of the coverage. In cooperating with the Medicaid payor, the
26 third party shall provide information upon the request of the
27 Medicaid payor in a manner prescribed by the Medicaid payor or
28 as agreed upon by the Medicaid payor and the third party.

29 b. (1) Accept the Medicaid payor's rights of recovery
30 and assignment to the Medicaid payor as a subrogee, assignee,
31 or lienholder under section 249A.54 for payments which the
32 Medicaid payor has made under the Medicaid state plan or under
33 a waiver of such state plan.

34 (2) In the case of a third party other than the original
35 Medicare fee-for-service program under parts A and B of Tit.

1 XVIII of the federal Social Security Act, a Medicare advantage
2 plan offered by a Medicare advantage organization under part C
3 of Tit. XVIII of the federal Social Security Act, a reasonable
4 cost reimbursement contract under 42 U.S.C. §1395mm, a health
5 care prepayment plan under 42 U.S.C. §1395l, or a prescription
6 drug plan offered by a prescription drug plan sponsor under
7 part D of Tit. XVIII of the federal Social Security Act that
8 requires prior authorization for an item or service furnished
9 to an individual eligible to receive medical assistance
10 under Tit. XIX of the federal Social Security Act, accept
11 authorization provided by the Medicaid payor that the health
12 care item or service is covered under the Medicaid state plan
13 or waiver of such state plan for such individual, as if such
14 authorization were the prior authorization made by the third
15 party for such item or service.

16 *c.* If, on or before three years from the date a health care
17 item or service was provided, the Medicaid payor submits an
18 inquiry regarding a claim for payment that was submitted to the
19 third party, respond to that inquiry not later than sixty days
20 after receiving the inquiry.

21 *d.* Respond to any Medicaid payor's request for payment of a
22 claim described in paragraph "c" not later than ninety business
23 days after receipt of written proof of the claim, either by
24 paying the claim or issuing a written denial to the Medicaid
25 payor.

26 *e.* Not deny any claim submitted by a Medicaid payor solely
27 on the basis of the date of submission of the claim, the type
28 or format of the claim form, a failure to present proper
29 documentation at the point-of-sale that is the basis of the
30 claim; or in the case of a third party other than the original
31 Medicare fee-for-service program under parts A and B of Tit.
32 XVIII of the federal Social Security Act, a Medicare advantage
33 plan offered by a Medicare advantage organization under part C
34 of Tit. XVIII of the federal Social Security Act, a reasonable
35 cost reimbursement contract under 42 U.S.C. §1395mm, a health

1 care prepayment plan under 42 U.S.C. §1395l, or a prescription
2 drug plan offered by a prescription drug plan sponsor under
3 part D of Tit. XVIII of the federal Social Security Act, solely
4 on the basis of a failure to obtain prior authorization for the
5 health care item or service for which the claim is submitted if
6 all of the following conditions are met:

7 (a) The claim is submitted to the third party by the
8 Medicaid payor no later than three years after the date on
9 which the health care item or service was furnished.

10 (b) Any action by the Medicaid payor to enforce its rights
11 under section 249A.54 with respect to such claim is commenced
12 not later than six years after the Medicaid payor submits the
13 claim for payment.

14 5. Notwithstanding any provision of law to the contrary,
15 the time limitations, requirements, and allowances specified
16 in this section shall apply to third-party obligations under
17 this section.

18 6. The department may adopt rules pursuant to chapter 17A
19 as necessary to administer this section. Rules governing
20 the exchange of information under this section shall be
21 consistent with all laws, regulations, and rules relating to
22 the confidentiality or privacy of personal information or
23 medical records, including but not limited to the federal
24 Health Insurance Portability and Accountability Act of 1996,
25 Pub. L. No. 104-191, and regulations promulgated in accordance
26 with that Act and published in 45 C.F.R. pts. 160 - 164.

27 Sec. 2. Section 249A.54, Code 2023, is amended by striking
28 the section and inserting in lieu thereof the following:

29 **249A.54 Responsibility for payment on behalf of**
30 **Medicaid-eligible persons — liability of other parties.**

31 1. It is the intent of the general assembly that a Medicaid
32 payor be the payor of last resort for medical services
33 furnished to recipients. All other sources of payment for
34 medical services are primary relative to medical assistance
35 provided by the Medicaid payor. If benefits of a third party

1 are discovered or become available after medical assistance has
2 been provided by the Medicaid payor, it is the intent of the
3 general assembly that the Medicaid payor be repaid in full and
4 prior to any other person, program, or entity. The Medicaid
5 payor shall be repaid in full from and to the extent of any
6 third-party benefits, regardless of whether a recipient is made
7 whole or other creditors are paid.

8 2. For the purposes of this section:

9 a. "*Collateral*" means all of the following:

10 (1) Any and all causes of action, suits, claims,
11 counterclaims, and demands that accrue to the recipient
12 or to the recipient's agent, related to any covered injury
13 or illness, or medical services that necessitated that the
14 Medicaid payor provide medical assistance to the recipient.

15 (2) All judgments, settlements, and settlement agreements
16 rendered or entered into and related to such causes of action,
17 suits, claims, counterclaims, demands, or judgments.

18 (3) Proceeds.

19 b. "*Covered injury or illness*" means any sickness, injury,
20 disease, disability, deformity, abnormality disease, necessary
21 medical care, pregnancy, or death for which a third party is,
22 may be, could be, should be, or has been liable, and for which
23 the Medicaid payor is, or may be, obligated to provide, or has
24 provided, medical assistance.

25 c. "*Medicaid payor*" means the department or any person,
26 entity, or organization that is legally responsible by
27 contract, statute, or agreement to pay claims for medical
28 assistance including but not limited to managed care
29 organizations and other entities that contract with the state
30 to provide medical assistance under chapter 249A.

31 d. "*Medical service*" means medical or medically related
32 institutional or noninstitutional care, or a medical or
33 medically related institutional or noninstitutional good, item,
34 or service covered by Medicaid.

35 e. "*Payment*" as it relates to third-party benefits, means

1 performance of a duty, promise, or obligation, or discharge of
2 a debt or liability, by the delivery, provision, or transfer of
3 third-party benefits for medical services. "To pay" means to
4 make payment.

5 *f.* "Proceeds" means whatever is received upon the sale,
6 exchange, collection, or other disposition of the collateral
7 or proceeds from the collateral and includes insurance payable
8 because of loss or damage to the collateral or proceeds. "Cash
9 proceeds" include money, checks, and deposit accounts and
10 similar proceeds. All other proceeds are "noncash proceeds".

11 *g.* "Recipient" means a person who has applied for medical
12 assistance or who has received medical assistance.

13 *h.* "Recipient's agent" includes a recipient's legal
14 guardian, legal representative, or any other person acting on
15 behalf of the recipient.

16 *i.* "Third party" means an individual, entity, or program,
17 excluding Medicaid, that is or may be liable to pay all or a
18 part of the expenditures for medical assistance provided by a
19 Medicaid payor to the recipient. A third party includes but is
20 not limited to all of the following:

- 21 (1) A third-party administrator.
- 22 (2) A pharmacy benefits manager.
- 23 (3) A health insurer.
- 24 (4) A self-insured plan.
- 25 (5) A group health plan, as defined in section 607(1) of the
26 federal Employee Retirement Income Security Act of 1974.
- 27 (6) A service benefit plan.
- 28 (7) A managed care organization.
- 29 (8) Liability insurance including self-insurance.
- 30 (9) No-fault insurance.
- 31 (10) Workers' compensation laws or plans.
- 32 (11) Other parties that by law, contract, or agreement
33 are legally responsible for payment of a claim for medical
34 services.

35 *j.* "Third-party benefits" mean any benefits that are or may

1 be available to a recipient from a third party and that provide
2 or pay for medical services. "Third-party benefits" may be
3 created by law, contract, court award, judgment, settlement,
4 agreement, or any arrangement between a third party and any
5 person or entity, recipient, or otherwise. "Third-party
6 benefits" include but are not limited to all of the following:

- 7 (1) Benefits from collateral or proceeds.
- 8 (2) Health insurance benefits.
- 9 (3) Health maintenance organization benefits.
- 10 (4) Benefits from preferred provider arrangements and
11 prepaid health clinics.
- 12 (5) Benefits from liability insurance, uninsured and
13 underinsured motorist insurance, or personal injury protection
14 coverage.
- 15 (6) Medical benefits under workers' compensation.
- 16 (7) Benefits from any obligation under law or equity to
17 provide medical support.

18 3. Third-party benefits for medical services shall be
19 primary to medical assistance provided by the Medicaid payor.

20 4. a. A Medicaid payor has all of the rights, privileges,
21 and responsibilities identified under this section. Each
22 Medicaid payor is a Medicaid payor to the extent of the
23 medical assistance provided by that Medicaid payor. Therefore,
24 Medicaid payors may exercise their Medicaid payor's rights
25 under this section concurrently.

26 b. Notwithstanding the provisions of this subsection to the
27 contrary, if the department determines that a Medicaid payor
28 has not taken reasonable steps within a reasonable time to
29 recover third-party benefits, the department may exercise all
30 of the rights of the Medicaid payor under this section to the
31 exclusion of the Medicaid payor. If the department determines
32 the department will exercise such rights, the department shall
33 give notice to third parties and to the Medicaid payor.

34 5. A Medicaid payor may assign the Medicaid payor's rights
35 under this section, including but not limited to an assignment

1 to another Medicaid payor, a provider, or a contractor.

2 6. After the Medicaid payor has provided medical assistance
3 under the Medicaid program, the Medicaid payor shall seek
4 reimbursement for third-party benefits to the extent of the
5 Medicaid payor's legal liability and for the full amount of
6 the third-party benefits, but not in excess of the amount of
7 medical assistance provided by the Medicaid payor.

8 7. On or before the thirtieth day following discovery by a
9 recipient of potential third-party benefits, a recipient and
10 the recipient's agent shall inform the Medicaid payor of any
11 rights the recipient has to third-party benefits and of the
12 name and address of any person that is or may be liable to
13 provide third-party benefits.

14 8. When the Medicaid payor provides or becomes liable for
15 medical assistance, the Medicaid payor has the following rights
16 which shall be construed together to provide the greatest
17 recovery of third-party benefits:

18 a. The Medicaid payor is automatically subrogated to any
19 rights that a recipient or a recipient's agent or legally
20 liable relative has to any third-party benefit for the full
21 amount of medical assistance provided by the Medicaid payor.
22 Recovery pursuant to these subrogation rights shall not be
23 reduced, prorated, or applied to only a portion of a judgment,
24 award, or settlement, but shall provide full recovery to the
25 Medicaid payor from any and all third-party benefits. Equities
26 of a recipient or a recipient's agent, creditor, or health care
27 provider shall not defeat, reduce, or prorate recovery by the
28 Medicaid payor as to the Medicaid payor's subrogation rights
29 granted under this paragraph.

30 b. By applying for, accepting, or accepting the benefit
31 of medical assistance, a recipient or a recipient's agent or
32 legally liable relative automatically assigns to the Medicaid
33 payor any right, title, and interest such person has to any
34 third-party benefit, excluding any Medicare benefit to the
35 extent required to be excluded by federal law.

1 (1) The assignment granted under this paragraph is absolute
2 and vests legal and equitable title to any such right in the
3 Medicaid payor, but not in excess of the amount of medical
4 assistance provided by the Medicaid payor.

5 (2) The Medicaid payor is a bona fide assignee for value in
6 the assigned right, title, or interest and takes vested legal
7 and equitable title free and clear of latent equities in a
8 third party. Equities of a recipient or a recipient's agent,
9 creditor, or health care provider shall not defeat or reduce
10 recovery by the Medicaid payor as to the assignment granted
11 under this paragraph.

12 c. The Medicaid payor is entitled to and has an automatic
13 lien upon the collateral for the full amount of medical
14 assistance provided by the Medicaid payor to or on behalf of
15 the recipient for medical services furnished as a result of any
16 covered injury or illness for which a third party is or may be
17 liable.

18 (1) The lien attaches automatically when a recipient first
19 receives medical services for which the Medicaid payor may be
20 obligated to provide medical assistance.

21 (2) The filing of the notice of lien with the clerk of
22 the district court in the county in which the recipient's
23 eligibility is established pursuant to this section shall be
24 notice of the lien to all persons. Notice is effective as of
25 the date of filing of the notice of lien.

26 (3) If the Medicaid payor knows that the recipient is
27 represented by an attorney, the Medicaid payor shall provide
28 the attorney with a copy of the notice of lien. However, this
29 provision of a copy of the notice of lien to the recipient's
30 attorney does not abrogate the attachment, perfection, and
31 notice satisfaction requirements specified under subparagraphs
32 (1) and (2).

33 (4) Only one claim of lien need be filed to provide notice
34 and shall provide sufficient notice as to any additional
35 or after-paid amount of medical assistance provided by the

1 Medicaid payor for any specific covered injury or illness.
2 The Medicaid payor may, in the Medicaid payor's discretion,
3 file additional, amended, or substitute notices of lien at any
4 time after the initial filing until the Medicaid payor has
5 been repaid the full amount of medical assistance provided
6 by Medicaid or otherwise has released the liable parties and
7 recipient.

8 (5) A release or satisfaction of any cause of action,
9 suit, claim, counterclaim, demand, judgment, settlement, or
10 settlement agreement shall not be effective as against a lien
11 created under this paragraph, unless the Medicaid payor joins
12 in the release or satisfaction or executes a release of the
13 lien. An acceptance of a release or satisfaction of any cause
14 of action, suit, claim, counterclaim, demand, or judgment and
15 any settlement of any of the foregoing in the absence of a
16 release or satisfaction of a lien created under this paragraph
17 shall prima facie constitute an impairment of the lien, and
18 the Medicaid payor is entitled to recover damages on account
19 of such impairment. In an action on account of impairment of a
20 lien, the Medicaid payor may recover from the person accepting
21 the release or satisfaction or the person making the settlement
22 the full amount of medical assistance provided by the Medicaid
23 payor.

24 (6) The lack of a properly filed claim of lien shall not
25 affect the Medicaid payor's assignment or subrogation rights
26 provided in this subsection nor affect the existence of the
27 lien, but shall only affect the effective date of notice.

28 (7) The lien created by this paragraph is a first lien
29 and superior to the liens and charges of any provider of a
30 recipient's medical services. If the lien is recorded, the
31 lien shall exist for a period of seven years after the date of
32 recording. If the lien is not recorded, the lien shall exist
33 for a period of seven years after the date of attachment. If
34 recorded, the lien may be extended for one additional period
35 of seven years by rerecording the claim of lien within the

1 ninety-day period preceding the expiration of the lien.

2 9. Except as otherwise provided in this section, the
3 Medicaid payor shall recover the full amount of all medical
4 assistance provided by the Medicaid payor on behalf of the
5 recipient to the full extent of third-party benefits. The
6 Medicaid payor may collect recovered benefits directly from any
7 of the following:

8 a. A third party.

9 b. The recipient.

10 c. The provider of a recipient's medical services if
11 third-party benefits have been recovered by the provider.
12 Notwithstanding any provision of this section to the contrary,
13 a provider shall not be required to refund or pay to the
14 Medicaid payor any amount in excess of the actual third-party
15 benefits received by the provider from a third party for
16 medical services provided to the recipient.

17 d. Any person who has received the third-party benefits.

18 10. a. A recipient and the recipient's agent shall
19 cooperate in the Medicaid payor's recovery of the recipient's
20 third-party benefits and in establishing paternity and support
21 of a recipient child born out of wedlock. Such cooperation
22 shall include but is not limited to all of the following:

23 (1) Appearing at an office designated by the Medicaid payor
24 to provide relevant information or evidence.

25 (2) Appearing as a witness at a court proceeding or other
26 legal or administrative proceeding.

27 (3) Providing information or attesting to lack of
28 information under penalty of perjury.

29 (4) Paying to the Medicaid payor any third-party benefit
30 received.

31 (5) Taking any additional steps to assist in establishing
32 paternity or securing third-party benefits, or both.

33 b. Notwithstanding paragraph "a", the Medicaid payor has the
34 discretion to waive, in writing, the requirement of cooperation
35 for good cause shown and as required by federal law.

1 *c.* The department may deny or terminate eligibility for
2 any recipient who refuses to cooperate as required under this
3 subsection unless the department has waived cooperation as
4 provided under this subsection.

5 11. On or before the thirtieth day following the initiation
6 of a formal or informal recovery, other than by filing a
7 lawsuit, a recipient's attorney shall provide written notice of
8 the activity or action to the Medicaid payor.

9 12. A recipient is deemed to have authorized the Medicaid
10 payor to obtain and release medical information and other
11 records with respect to the recipient's medical services
12 for the sole purpose of obtaining reimbursement for medical
13 assistance provided by the Medicaid payor.

14 13. *a.* To enforce the Medicaid payor's rights under
15 this section, the Medicaid payor may, as a matter of right,
16 institute, intervene in, or join in any legal or administrative
17 proceeding in the Medicaid payor's own name, and in any or a
18 combination of any, of the following capacities:

- 19 (1) Individually.
20 (2) As a subrogee of the recipient.
21 (3) As an assignee of the recipient.
22 (4) As a lienholder of the collateral.

23 *b.* An action by the Medicaid payor to recover damages
24 in an action in tort under this subsection, which action is
25 derivative of the rights of the recipient, shall not constitute
26 a waiver of sovereign immunity.

27 *c.* If the recipient or a recipient's agent brings an action
28 against a third party, on or before the thirtieth day following
29 the filing of the action, the recipient, the recipient's agent,
30 or the attorney of the recipient or the recipient's agent,
31 as applicable, shall provide written notice to the Medicaid
32 payor of the action, including the name of the court in which
33 the action is brought, the case number of the action, and a
34 copy of the pleadings. The recipient, the recipient's agent,
35 or the attorney of the recipient or the recipient's agent, as

1 applicable, shall provide written notice of intent to dismiss
2 the action at least twenty-one days before the voluntary
3 dismissal of an action against a third party. Notice to the
4 Medicaid payor shall be sent as specified by rule.

5 14. On or before the thirtieth day before the recipient
6 finalizes a judgment, award, settlement, or any other recovery
7 where the Medicaid payor has the right to recovery, the
8 recipient, the recipient's agent, or the attorney of the
9 recipient or recipient's agent, as applicable, shall give the
10 Medicaid payor notice of the judgment, award, settlement,
11 or recovery. The judgment, award, settlement, or recovery
12 shall not be finalized unless such notice is provided and
13 the Medicaid payor has had a reasonable opportunity to
14 recover under the Medicaid payor's rights to subrogation,
15 assignment, and lien. If the Medicaid payor is not given
16 appropriate notice, the recipient, the recipient's agent, and
17 the recipient's or recipient's agent's attorney are jointly
18 and severally liable to reimburse the Medicaid payor for the
19 recovery received to the extent of medical assistance paid by
20 the Medicaid payor.

21 15. *a.* Except as otherwise provided in this section, the
22 entire amount of any settlement of the recipient's action or
23 claim involving third-party benefits, with or without suit, is
24 subject to the Medicaid payor's claim for reimbursement of the
25 amount of medical assistance provided and any lien pursuant to
26 the claim.

27 *b.* Insurance and other third-party benefits shall not
28 contain any term or provision which purports to limit or
29 exclude payment or the provision of benefits for an individual
30 if the individual is eligible for, or a recipient of, medical
31 assistance, and any such term or provision shall be void as
32 against public policy.

33 16. In an action in tort against a third party in which the
34 recipient is a party and which results in a judgment, award, or
35 settlement from a third party, the amount recovered shall be

1 distributed as follows:

2 *a.* After reasonable attorney fees and filing fees, there
3 is a rebuttable presumption that all Medicaid payors shall
4 collectively receive two-thirds of the remaining amount
5 recovered or the total amount of medical assistance provided by
6 the Medicaid payors, whichever is less. A party may rebut this
7 presumption in accordance with subsection 17.

8 *b.* The remaining recovered amount shall be paid to the
9 recipient.

10 *c.* For purposes of calculating the Medicaid payor's
11 recovered amount of medical assistance, the fee for services of
12 an attorney retained by the recipient or the recipient's legal
13 representative shall not exceed one-third of the judgment,
14 award, or settlement amount.

15 *d.* If the recovered amount available for the repayment of
16 medical assistance is insufficient to satisfy the competing
17 claims of the Medicaid payors, each Medicaid payor shall be
18 entitled to the Medicaid payor's respective pro rata share of
19 the recovered amount that is available.

20 17. *a.* A recipient or a recipient's agent who has notice
21 or who has actual knowledge of the Medicaid payor's rights
22 to third-party benefits under this section and who receives
23 any third-party benefit or proceeds for a covered injury or
24 illness shall on or before the sixtieth day after receipt of
25 the proceeds pay the Medicaid payor the full amount of the
26 third-party benefits, but not more than the total medical
27 assistance provided by the Medicaid payor, or shall place the
28 full amount of the third-party benefits in an interest-bearing
29 trust account for the benefit of the Medicaid payor pending a
30 determination of the Medicaid payor's rights to the benefits
31 under this subsection.

32 *b.* If federal law limits the Medicaid payor to reimbursement
33 from the recovered damages for medical expenses, a recipient
34 may contest the amount designated as recovered damages for
35 medical expenses payable to the Medicaid payor pursuant to the

1 formula specified in subsection 16. In order to successfully
2 rebut the formula specified in subsection 16, the recipient
3 shall prove, by clear and convincing evidence, that the portion
4 of the total recovery which should be allocated as medical
5 expenses, including future medical expenses, is less than the
6 amount calculated by the Medicaid payor pursuant to the formula
7 specified in subsection 16. Alternatively, to successfully
8 rebut the formula specified in subsection 16, the recipient
9 shall prove, by clear and convincing evidence, that Medicaid
10 provided a lesser amount of medical assistance than that
11 asserted by the Medicaid payor. A settlement agreement that
12 designates the amount of recovered damages for medical expenses
13 is not clear and convincing evidence and is not sufficient to
14 establish the recipient's burden of proof, unless the Medicaid
15 payor is a party to the settlement agreement.

16 *c.* If the recipient or the recipient's agent filed a legal
17 action to recover against the third party, the court in which
18 such action was filed shall resolve any dispute concerning
19 the amount owed to the Medicaid payor, and shall retain
20 jurisdiction of the case to resolve the amount of the lien
21 after the dismissal of the action.

22 *d.* If the recipient or the recipient's agent did not file a
23 legal action, to resolve any dispute concerning the amount owed
24 to the Medicaid payor, the recipient or the recipient's agent
25 shall file a petition for declaratory judgment as permitted
26 under rule of civil procedure 1.1101 on or before the one
27 hundred twenty-first day after the date of payment of funds to
28 the Medicaid payor or the date of placing the full amount of
29 the third-party benefits in a trust account. Venue for all
30 declaratory actions under this subsection shall lie in Polk
31 county.

32 *e.* Each party shall pay the party's own attorney fees and
33 costs for any legal action conducted under this subsection.

34 18. Notwithstanding any other provision of law to the
35 contrary, when medical assistance is provided for a minor, any

1 statute of limitation or repose applicable to an action or
2 claim of a legally responsible relative for the minor's medical
3 expenses is extended in favor of the legally responsible
4 relative so that the legally responsible relative shall have
5 one year from and after the attainment of the minor's majority
6 within which to file a complaint, make a claim, or commence an
7 action.

8 19. In recovering any payments in accordance with this
9 section, the Medicaid payor may make appropriate settlements.

10 20. The department may adopt rules to administer this
11 section and applicable federal requirements.

12

DIVISION II

13

MEDICAID MANAGED CARE ORGANIZATION TAXATION OF PREMIUMS

14

Sec. 3. NEW SECTION. 249A.13 Medicaid managed care

15

organization premiums fund.

16

1. A Medicaid managed care organization premiums fund
17 is created in the state treasury under the authority of the
18 department of health and human services. Moneys collected by
19 the director of the department of revenue as taxes on premiums
20 pursuant to section 432.1A shall be deposited in the fund.

21

2. Moneys in the fund are appropriated to the department
22 of health and human services for the purposes of the medical
23 assistance program.

24

3. Notwithstanding section 8.33, moneys in the fund
25 that remain unencumbered or unobligated at the close of a
26 fiscal year shall not revert but shall remain available for
27 expenditure for the purposes designated. Notwithstanding
28 section 12C.7, subsection 2, interest or earnings on moneys in
29 the fund shall be credited to the fund.

30

Sec. 4. NEW SECTION. 432.1A Health maintenance organization
31 — medical assistance program — premium tax.

32

1. Pursuant to section 514B.31, subsection 3, a health
33 maintenance organization contracting with the department of
34 health and human services to administer the medical assistance
35 program under chapter 249A, shall pay as taxes to the director

1 of the department of revenue for deposit in the Medicaid
2 managed care organization premiums fund created in section
3 249A.13, an amount equal to two and one-half percent of
4 the premiums received and taxable under subsection 514B.31,
5 subsection 3.

6 2. Except as provided in subsection 3, the premium tax shall
7 be paid on or before March 1 of the year following the calendar
8 year for which the tax is due. The commissioner of insurance
9 may suspend or revoke the license of a health maintenance
10 organization subject to the premium tax in subsection 1 that
11 fails to pay the premium tax on or before the due date.

12 3. *a.* Each health maintenance organization transacting
13 business in this state that is subject to the tax in subsection
14 1 shall remit on or before June 1, on a prepayment basis,
15 an amount equal to one-half of the health maintenance
16 organization's premium tax liability for the preceding calendar
17 year.

18 *b.* In addition to the prepayment amount in paragraph
19 "a", each health maintenance organization subject to the
20 tax in subsection 1 shall remit on or before August 15, on
21 a prepayment basis, an additional one-half of the health
22 maintenance organization's premium tax liability for the
23 preceding calendar year.

24 *c.* The sums prepaid by a health maintenance organization
25 under paragraphs "a" and "b" shall be allowed as credits
26 against the health maintenance organization's premium tax
27 liability for the calendar year during which the payments are
28 made. If a prepayment made under this subsection exceeds
29 the health maintenance organization's annual premium tax
30 liability, the excess shall be allowed as a credit against the
31 health maintenance organization's subsequent prepayment or tax
32 liabilities under this section. The commissioner of insurance
33 shall authorize the department of revenue to make a cash refund
34 to a health maintenance organization, in lieu of a credit
35 against subsequent prepayment or tax liabilities under this

1 section, if the health maintenance organization demonstrates
2 the inability to recoup the funds paid via a credit. The
3 commissioner of insurance shall adopt rules establishing a
4 health maintenance organization's eligibility for a cash
5 refund, and the process for the department of revenue to make a
6 cash refund to an eligible health maintenance organization from
7 the Medicaid managed care organization premiums fund created in
8 section 249A.13. The commissioner of insurance may suspend or
9 revoke the license of a health maintenance organization that
10 fails to make a prepayment on or before the due date under this
11 subsection.

12 Sec. 5. Section 514B.31, Code 2023, is amended by striking
13 the section and inserting in lieu thereof the following:

14 **514B.31 Taxation.**

15 1. For the first five years of the existence of a
16 health maintenance organization and the health maintenance
17 organization's successors and assigns, the following shall
18 not be considered premiums received and taxable under section
19 432.1:

20 a. Payments received by the health maintenance organization
21 for health care services, insurance, indemnity, or other
22 benefits to which an enrollee is entitled through a health
23 maintenance organization authorized under this chapter.

24 b. Payments made by the health maintenance organization
25 to providers for health care services, to insurers, or to
26 corporations authorized under chapter 514 for insurance,
27 indemnity, or other service benefits authorized under this
28 chapter.

29 2. After the first five years of the existence of a
30 health maintenance organization and the health maintenance
31 organization's successors and assigns, the following shall be
32 considered premiums received and taxable under section 432.1:

33 a. Payments received by the health maintenance organization
34 for health care services, insurance, indemnity, or other
35 benefits to which an enrollee is entitled through a health

1 maintenance organization authorized under this chapter.

2 *b.* Payments made by the health maintenance organization
3 to providers for health care services, to insurers, or to
4 corporations authorized under chapter 514 for insurance,
5 indemnity, or other service benefits authorized under this
6 chapter.

7 3. Notwithstanding subsections 1 and 2, beginning January
8 1, 2024, and for each subsequent calendar year, the following
9 shall be considered premiums received and taxable under section
10 432.1A for a health maintenance organization contracting with
11 the department of health and human services to administer the
12 medical assistance program under chapter 249A:

13 *a.* Payments received by the health maintenance organization
14 for health care services, insurance, indemnity, or other
15 benefits to which an enrollee is entitled through a health
16 maintenance organization authorized under this chapter.

17 *b.* Payments made by the health maintenance organization
18 to providers for health care services, to insurers, or to
19 corporations authorized under chapter 514 for insurance,
20 indemnity, or other service benefits authorized under this
21 chapter.

22 4. Payments made to a health maintenance organization
23 by the United States secretary of health and human services
24 under a contract issued under section 1833 or 1876 of the
25 federal Social Security Act, or under section 4015 of the
26 federal Omnibus Budget Reconciliation Act of 1987, shall not
27 be considered premiums received and shall not be taxable
28 under section 432.1. Payments made to a health maintenance
29 organization contracting with the department of health and
30 human services to administer the medical assistance program
31 under chapter 249A shall not be taxable under section 432.1.

32 EXPLANATION

33 The inclusion of this explanation does not constitute agreement with
34 the explanation's substance by the members of the general assembly.

35 This bill relates to the Medicaid program including recovery

1 by the department of health and human services (HHS or the
2 department) from third parties and taxation of Medicaid managed
3 care organization premiums.

4 DIVISION I — MEDICAID PROGRAM THIRD-PARTY RECOVERY. The
5 bill strikes and replaces current provisions in Code section
6 249A.37 (health care information sharing) and Code section
7 249A.54 (assignment — lien).

8 Under the bill, new Code section 249A.37 (duties of third
9 parties) relates to the duties of third parties, defined
10 under the bill as "an individual, entity, or program,
11 excluding Medicaid, that is or may be liable to pay all or
12 a part of the expenditures for medical assistance provided
13 by a Medicaid payor to the recipient". The listing of
14 "third parties" includes but is not limited to a third-party
15 administrator, a pharmacy benefits manager, a health insurer, a
16 self-insured plan, a group health plan, a service benefit plan,
17 a managed care organization, liability insurance including
18 self-insurance, no-fault insurance, workers' compensation laws
19 or plans, and other parties that by law, contract, or agreement
20 are legally responsible for payment of a claim for a medical
21 service. The bill also defines terms including "Medicaid
22 payor", "recipient", "third party", and "third-party benefits".

23 The bill provides that the third-party obligations specified
24 under the bill are a condition of doing business in the state,
25 and a third party that fails to comply with these obligations
26 shall not be eligible to do business in the state.

27 The bill requires that a third party that is a carrier shall
28 enter into a health insurance data match program with HHS
29 for the sole purpose of comparing the names of the carrier's
30 insureds with the names of recipients as required by Code
31 section 505.25 (information provided to medical assistance
32 program, hawk-i program, and child support recovery unit).

33 The bill specifies the duties of a third party under the
34 Medicaid program including cooperating with the Medicaid payor
35 in identifying recipients for whom third-party benefits are

1 available; accepting the Medicaid payor's rights of recovery
2 and assignment to the Medicaid payor for payments which the
3 Medicaid payor has made; accepting authorization provided by
4 the Medicaid payor that the health care item or service is
5 covered as if such authorization were the prior authorization
6 made by the third party for such health care item or service;
7 responding to inquiries from Medicaid payors regarding claims
8 for payment; and not denying claims submitted by a Medicaid
9 payor solely on the basis of the date of submission of the
10 claim, the type or format of the claim form, a failure to
11 present proper documentation, or in the case of specified
12 third-party payors solely on the basis of a failure to obtain
13 prior authorization if certain conditions are met.

14 The department may adopt administrative rules to administer
15 this Code section of the bill. Rules governing the exchange
16 of information under the bill shall be consistent with all
17 laws, regulations, and rules relating to the confidentiality or
18 privacy of personal information or medical records, including
19 but not limited to the federal Health Insurance Portability
20 and Accountability Act (HIPAA) and regulations promulgated in
21 accordance with HIPAA.

22 Under new Code section 249A.54 (responsibility for payment
23 on behalf of Medicaid-eligible persons — liability of other
24 parties) the bill includes specific provisions relating to the
25 responsibility for payment on behalf of Medicaid recipients,
26 which include both persons who have applied for and persons
27 who have received medical assistance, when other parties are
28 liable.

29 The bill provides that it is the intent of the general
30 assembly that Medicaid payors be the payor of last resort for
31 medical services furnished to recipients. All other sources of
32 payment for medical services are primary relative to medical
33 assistance provided by the Medicaid payor. If benefits of a
34 third party are discovered or become available after medical
35 assistance has been provided by the Medicaid payor, it is

1 the intent of the general assembly that the Medicaid payor
2 be repaid in full and prior to any other person, program, or
3 entity. The Medicaid payor shall be repaid in full from and to
4 the extent of any third-party benefits, regardless of whether a
5 recipient is made whole or other creditors paid.

6 The bill provides definitions for "collateral", "covered
7 injury or illness", "Medicaid payor", "medical service",
8 "payment", "proceeds", "recipient" which includes both an
9 applicant for and recipient of medical assistance, "recipient's
10 agent", "third party", and "third-party benefits".

11 The bill provides that third-party benefits for medical
12 services shall be primary relative to medical assistance
13 provided by the Medicaid payor. A Medicaid payor has all of
14 the rights, privileges, and responsibilities identified under
15 the bill, but if HHS determines that a Medicaid payor has not
16 taken reasonable steps within a reasonable time to recover
17 third-party benefits, HHS may exercise all of the rights of the
18 Medicaid payor to the exclusion of the Medicaid payor following
19 provision of notice to third parties and the Medicaid payor.

20 A Medicaid payor may assign the Medicaid payor's rights
21 under the bill, including to another Medicaid payor, a
22 provider, or a contractor. After the Medicaid payor has
23 provided medical assistance, the Medicaid payor shall seek
24 reimbursement for third-party benefits to the extent of the
25 Medicaid payor's legal liability and for the full amount of
26 the third-party benefits, but not in excess of the amount of
27 medical assistance provided by the Medicaid payor.

28 Within 30 days following discovery by a recipient of
29 potential third-party benefits, a recipient and the recipient's
30 agent shall inform the Medicaid payor of any rights the
31 recipient has to third-party benefits and provide identifying
32 information for any person that is or may be liable to provide
33 third-party benefits.

34 The bill specifies the rights of a Medicaid payor when
35 the Medicaid payor provides or becomes liable for medical

1 assistance, including that the Medicaid payor is automatically
2 subrogated to any rights that a recipient or a recipient's
3 agent or legally liable relative has to any third-party
4 benefit for the full amount of medical assistance provided by
5 the Medicaid payor; that the Medicaid payor is automatically
6 assigned any right, title, and interest a recipient or
7 a recipient's agent or legally liable relative has to a
8 third-party benefit by virtue of applying for, accepting, or
9 accepting the benefit of medical assistance, excluding any
10 Medicare benefit to the extent required to be excluded by
11 federal law; and that the Medicaid payor is entitled to and
12 has an automatic lien upon the collateral for the full amount
13 of medical assistance provided by the Medicaid payor to or on
14 behalf of the recipient for medical services furnished as a
15 result of any covered injury or illness for which a third party
16 is or may be liable.

17 Unless otherwise provided in the bill, the Medicaid payor
18 shall recover the full amount of all medical assistance
19 provided by the Medicaid payor on behalf of the recipient
20 to the full extent of third-party benefits. A recipient
21 and the recipient's agent shall cooperate in the Medicaid
22 payor's recovery of the recipient's third-party benefits and
23 in establishing paternity and support of a recipient child
24 born out of wedlock. The Medicaid payor has the discretion
25 to waive, in writing, the requirement of cooperation for good
26 cause shown and as required by federal law. The department may
27 deny or terminate eligibility for any recipient who refuses to
28 cooperate, unless HHS has waived cooperation.

29 Within 30 days of initiating formal or informal recovery,
30 other than by filing a lawsuit, a recipient's attorney shall
31 provide written notice of the activity or action to the
32 Medicaid payor.

33 A recipient is deemed to have authorized the Medicaid payor
34 to obtain and release medical information and other records
35 with respect to the recipient's medical services for the sole

1 purpose of obtaining reimbursement for medical assistance
2 provided by the Medicaid payor.

3 To enforce the Medicaid payor's rights, the Medicaid
4 payor may institute, intervene in, or join in any legal or
5 administrative proceeding in the Medicaid payor's own name, and
6 in a number or a combination of capacities listed in the bill.
7 An action by the Medicaid payor to recover damages in an action
8 in tort, which is derivative of the rights of the recipient,
9 shall not constitute a waiver of sovereign immunity.

10 If an action is filed by a recipient or a recipient's agent
11 against a third party, the recipient, the recipient's agent,
12 or the attorney of the recipient or the recipient's agent,
13 as applicable, shall provide written notice to the Medicaid
14 payor of the action, including the name of the court in which
15 the action is brought, the case number of the action, and a
16 copy of the pleadings. The recipient, the recipient's agent,
17 or the attorney of the recipient or the recipient's agent,
18 as applicable, shall also provide written notice of intent
19 to dismiss the action prior to the voluntary dismissal of an
20 action against a third party.

21 Before a recipient finalizes a judgment, award, settlement,
22 or any other recovery where the Medicaid payor has the right
23 to recovery, the recipient, the recipient's agent, or the
24 attorney of the recipient or recipient's agent, as applicable,
25 shall give the Medicaid payor notice of the judgment, award,
26 settlement, or recovery. The judgment, award, settlement,
27 or recovery shall not be finalized unless the notice is
28 provided and the Medicaid payor has a reasonable opportunity
29 to recover under its rights to subrogation, assignment, and
30 lien. If appropriate notice is not provided, the recipient,
31 the recipient's agent, and the recipient's or recipient's
32 agent's attorney are jointly and severally liable to reimburse
33 the Medicaid payor for the recovery received to the extent of
34 medical assistance paid by the Medicaid payor.

35 Unless otherwise provided, the entire amount of any

1 settlement of the recipient's action or claim involving
2 third-party benefits is subject to the Medicaid payor's claim
3 for reimbursement of the amount of medical assistance provided
4 and any lien pursuant to the claim.

5 The bill prohibits insurance and other third-party benefits
6 from containing any term or provision which purports to
7 limit or exclude payment or the provision of benefits for an
8 individual if the individual is eligible for, or a recipient
9 of, medical assistance, and any such term or provision shall be
10 void as against public policy.

11 In an action in tort against a third party in which the
12 recipient is a party, of the amount recovered in any resulting
13 judgment, award, or settlement from a third party, after
14 reasonable attorney fees and filing fees, there is a rebuttable
15 presumption that all Medicaid payors shall receive two-thirds
16 of the remaining amount recovered or the total amount of
17 medical assistance provided by the Medicaid payors, whichever
18 is less; and the remaining amount recovered shall be paid to
19 the recipient. In calculating the Medicaid payor's recovered
20 amount of medical assistance, the fee for services of an
21 attorney retained by the recipient or the recipient's legal
22 representative shall not exceed one-third of the judgment,
23 award, or settlement amount. If the recovered amount is
24 insufficient to satisfy the competing claims of the Medicaid
25 payors, each Medicaid payor shall be entitled to the Medicaid
26 payor's respective pro rata share of the recovered amount that
27 is available.

28 A recipient or a recipient's agent who has notice or
29 who has actual knowledge of the Medicaid payor's rights to
30 third-party benefits who receives any third-party benefit or
31 proceeds for a covered injury or illness, shall after receipt
32 of the proceeds pay the Medicaid payor the full amount of the
33 third-party benefits, but not more than the total medical
34 assistance provided by the Medicaid payor, or shall place the
35 full amount of the third-party benefits in an interest-bearing

1 trust account for the benefit of the Medicaid payor pending a
2 determination of the Medicaid payor's rights to the benefits.

3 If federal law limits the Medicaid payor to reimbursement
4 from the recovered damages for medical expenses, a recipient
5 may contest the amount designated as recovered damages for
6 medical expenses payable to the Medicaid payor as specified
7 in the formula under the bill. To successfully rebut the
8 formula, the recipient shall prove, by clear and convincing
9 evidence, that the portion of the total recovery which should
10 be allocated as medical expenses, including future medical
11 expenses, is less than the amount calculated by the Medicaid
12 payor pursuant to the formula. Alternatively, to successfully
13 rebut the formula, the recipient shall prove, by clear and
14 convincing evidence, that Medicaid provided a lesser amount of
15 medical assistance than that asserted by the Medicaid payor. A
16 settlement agreement that designates the amount of recovered
17 damages for medical expenses is not clear and convincing
18 evidence and is not sufficient to establish the recipient's
19 burden of proof, unless the Medicaid payor is a party to the
20 settlement agreement.

21 If the recipient or the recipient's agent filed a legal
22 action to recover against the third party, the court in which
23 such action was filed shall resolve any dispute concerning
24 the amount owed to the Medicaid payor, and shall retain
25 jurisdiction of the case to resolve the amount of the lien
26 after the dismissal of the action. If the recipient or the
27 recipient's agent did not file a legal action to resolve any
28 dispute concerning the amount owed to the Medicaid payor, the
29 recipient or the recipient's agent shall file a petition for
30 declaratory judgment. Venue for all such declaratory actions
31 shall lie in Polk county. Each party shall pay the party's own
32 attorney fees and costs for any legal action conducted under
33 this provision of the bill.

34 With regard to medical assistance provided to a minor, and
35 notwithstanding any other provision of law to the contrary, any

1 statute of limitations or repose applicable to an action or
2 claim of a legally responsible relative for the minor's medical
3 expenses is extended in favor of the legally responsible
4 relative so that the legally responsible relative shall have
5 one year from and after the attainment of the minor's majority
6 within which to file a complaint, make a claim, or commence an
7 action.

8 In recovering any payments under the bill, the Medicaid
9 payor may make appropriate settlements. The department may
10 adopt administrative rules to administer this portion of the
11 bill and applicable federal requirements.

12 DIVISION II — MEDICAID MANAGED CARE ORGANIZATION

13 TAXATION OF PREMIUMS. The bill relates to taxation of health
14 maintenance organizations.

15 Under current Code section 514B.31 (taxation), for the
16 first five years of the existence of a health maintenance
17 organization (HMO) or its successor, payments received by the
18 HMO for health care services, insurance, indemnity, or other
19 benefits to which an enrollee is entitled, and payments made by
20 the HMO to a provider for health care services, to insurers, or
21 to corporations authorized under Code chapter 514 (nonprofit
22 health services corporations) for insurance, indemnity, or
23 other service benefits, are not considered premiums received
24 and not taxable under Code section 432.1 (tax on gross premiums
25 — exclusions). After five years, payments received by the
26 HMO or its successor for health care services, insurance,
27 indemnity, or other benefits to which an enrollee is entitled,
28 and payments made by the HMO to a provider for health care
29 services, to insurers, or to corporations authorized under
30 Code chapter 514 (nonprofit health services corporations)
31 for insurance, indemnity, or other service benefits, are
32 considered premiums received and taxable under Code section
33 432.1. Current Code section 514B.31 also provides that certain
34 payments made by the United States secretary of health and
35 human services are not considered premiums and therefore not

1 taxable under Code section 432.1.

2 The provisions of current Code section 514B.31 continue
3 under the bill, except that the exclusion from consideration
4 as premiums of payments made by the United States secretary
5 of health and human services under Code chapter 249A (medical
6 assistance) is eliminated and replaced with language that
7 instead specifies that payments made to an HMO contracting
8 with HHS under Code chapter 249A shall not be taxable under
9 Code section 432.1, thereby exempting all payments to
10 these particular HMOs from consideration as premiums and
11 correspondingly from taxation under Code section 432.1. The
12 bill also amends current Code section 514B.31 to provide that
13 notwithstanding the provisions applicable to HMOs under Code
14 section 514B.31 relating to a premium tax, beginning January
15 1, 2024, and for each subsequent calendar year, for an HMO
16 contracting with HHS to administer the medical assistance
17 program under Code chapter 249A, payments received by the
18 HMO for health care services, insurance, indemnity, or other
19 benefits to which an enrollee is entitled, and payments made by
20 the HMO to a provider for health care services, to insurers,
21 or to corporations authorized under Code chapter 514 for
22 insurance, indemnity, or other service benefits, are considered
23 premiums received and taxable under new Code section 432.1A.

24 The bill establishes under new Code section 432.1A (health
25 maintenance organization — medical assistance program —
26 premium tax) the parameters of the new tax on HMOs contracting
27 with HHS to administer the medical assistance program under
28 Code chapter 249A. Such HMOs shall pay as taxes to the
29 director of the department of revenue for deposit in the
30 Medicaid managed care organization premiums fund an amount
31 equal to 2.5 percent of the premiums received and taxable. The
32 premium tax shall be paid on or before March 1 of the year
33 following the calendar year for which the tax is due. The
34 commissioner of insurance may suspend or revoke the license of
35 an HMO subject to the premium tax that fails to pay the premium

1 tax on or before the due date.

2 An HMO subject to the new tax shall remit on or before June
3 1, on a prepayment basis, an amount equal to one-half of the
4 HMO's premium tax liability for the preceding calendar year;
5 and shall remit on or before August 15, on a prepayment basis,
6 an additional one-half of the HMO's premium tax liability
7 for the preceding calendar year. If a prepayment exceeds
8 the HMO's annual premium tax liability, the excess shall be
9 allowed as a credit against the HMO's subsequent prepayment
10 or tax liabilities. The HMO may receive a credit or a cash
11 refund in lieu of a credit against subsequent prepayment or
12 tax liabilities. The commissioner of insurance may suspend or
13 revoke the license of an HMO that fails to make a prepayment on
14 or before the due date.

15 The bill creates in new Code section 249A.13 a Medicaid
16 managed care organization premiums fund in the state treasury
17 under the authority of HHS. Moneys collected from the new
18 tax on premiums shall be deposited in the fund. Moneys in
19 the fund are appropriated to HHS for the purposes of the
20 medical assistance program. Moneys in the fund that remain
21 unencumbered or unobligated at the close of a fiscal year shall
22 not revert but shall remain available for expenditure for the
23 purposes designated. Interest or earnings on moneys in the
24 fund shall be credited to the fund.